Cincinnati State Health and Public Safety Division
Student Physical Evaluation Form

Last Name	**First Name**	**Middle Initial**
Date of Birth (MM/DD/YYYY)	**Student ID**	

1) **Did you conduct a physical exam**? Yes ☐ No ☐

2) **Is this individual free of communicable diseases** that would prohibit direct patient care in a healthcare or homecare setting? Yes ☐ No ☐

3) We need to know if there are any findings that would limit or prevent this individual from fulfilling assigned work duties related to direct patient care. These duties may include moving and positioning patients, bending, performing therapies, patient assessment, airway management, BLS, standing or walking for up to 12 hours, and being able to manipulate equipment with small parts. Based on your physical examination, **is it your qualified opinion that this student can perform these or other related patient care duties without limitation or restriction?**

☐ Yes ☐ No

Please list any restrictions and any reasonable applicable accommodations that would need to be made to allow for direct patient care: ____

____

4) **Is this individual able to wear a respirator mask?**

Yes ☐ No ☐

____
Name and title of physician or qualified personnel (Please print)

____
Signature of physician or NP Date

____
Telephone Number

____
Address

IMMUNIZATIONS

Please fill out this form and additionally submit a copy of all vaccination and lab value records. An annual Flu Vaccination is also required and is submitted separately.

Hepatitis B: #1 _____/_____/_____ #2 _____/_____/_____ #3 _____/_____/_____

OR Positive Titer: Date ___________ Result ______

Varicella: Varicella Vaccination: Dates #1 _____/_____/_____ #2 _____/_____/_____

OR Positive Titer: Date _____/_____/_____ Result ______

Tdap: (Tetanus, Diptheria, & Pertussis) Date (must be after 2005): Date _____/_____/_____

MMR: (Measles, Mumps, Rubella), one of which must be 1980 or later:

Dates: #1 _____/_____/_____ #2 _____/_____/_____

OR Positive Titer: Date _____/_____/_____ Results: Measles _____ Mumps _____ Rubella _____

TB Test: If you have not had a 2 step TB test within the past year, a recent 2 Step Tb Test is required. If you have had a TB test in the past year, provide documentation of last year's test and then only a 1 step is required for this year. You may alternatively submit a Quantiferon Gold test in place of a 1 or 2 step test.

#1 Date Applied ____/____/____ Date Read ____/____/____ Result ______mm Signature & Title __________________

#2 Date Applied ____/____/____ Date Read ____/____/____ Result ______mm Signature & Title __________________

OR 1 Quantiferon Gold blood test: Date ____/____/____ Result ______ Signature & Title _____________________

If positive PPD reaction, the positive PPD test result AND a recent chest x-ray showing no evidence of active TB must be submitted
(results attached) _______ Yes

____

Signature of physician or NP Date

Student:
I certify that the information above is true and complete to the best of my knowledge. I understand that it is my responsibility to immediately notify my Program Director or Clinical Coordinator of any relevant change in my overall health while I am enrolled my Program. I authorize Cincinnati State to release this information, as necessary, to any clinical facility utilized as part of my educational experience, or in the event of an emergency.

Students must supply this original form and attached copies of lab documentation and keep a copy for their records. The Program Director will **NOT** copy immunizations or re-furnish immunization documentation to students for their own records, or for third parties (e.g. employers).

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Student Signature Date